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CALIFORNIA MEDICAL ASSISTANCE COMMISSION

State Capitol, Room 4203
Sacramento, CA

Minutes of Meeting

January 12, 2006

COMMISSIONERS PRESENT
Michele Burton, M.P.H.
Marco Firebaugh
Diane M. Griffiths
Teresa P. Hughes
Lynn Schenk
Vicki Marti
Cathie Bennett Warner

CMAC STAFF PRESENT
Keith Berger, Executive Director
Enid Barnes
Paul Cerles
Theresa Bueno
Denise DeTrano
Holland Golec
Cecilia Lacoste
Steve Soto
Michael Tagupa
Mervin Tamai
Carol Tate
Karen Thalhammer

EX-OFFICIO MEMBERS PRESENT
Bob Sands, Department of Finance
Toby Douglas, Department of Health Services

I. Call to Order

The January 12, 2006 open session meeting of the California Medical Assistance Commission (CMAC) was called to order by Commissioner Cathie Bennett Warner. Commissioner Warner welcomed the Commission to the first Commission meeting of 2006. A quorum was present.

II. Approval of Minutes

The December 8, 2005 meeting minutes were approved as prepared by CMAC staff.

III. Executive Director's Report

Mr. Berger also welcomed the Commission back and wished everyone a Happy New Year.

Mr. Berger took a few minutes to brief everyone on today's agenda. He explained that the first part of the open session will be brief. The Commission will go into closed session to address contracts and amendments before the Commission for action. Members of the public will be asked to leave the room while the Commission addresses closed session issues. Once the closed session issues have been dealt with, the Commission will reconvene in open session and provide interested parties an opportunity to share with the Commission their thoughts on issues that the Commission should consider in the development and implementation of the Distressed Hospital Fund.

Mr. Berger informed the audience that there was a sign-in sheet for anyone who wanted to address the Commission regarding the Distressed Hospital Fund.

Mr. Berger informed the Commissioners that there are ten amendments and contracts for action during today's closed session, as well as some updates and strategic discussions on current negotiations.

Mr. Berger noted that CMAC staff has provided the Commissioners with a draft schedule of proposed meeting dates for the next fiscal year, 2006-07, for review. A final draft schedule will be available for approval at the January 26 Commission meeting. If there are any questions or concerns Mr. Berger requested that Commissioners contact Theresa Bueno.

At this time, Mr. Berger took a moment to introduce CMAC's new Administrative Assistant, Cecilia Lacoste. She is replacing Charlotte Nuzum who retired at the end of December. Ms. Lacoste joins CMAC after several years of service at the Governor's Office. Ms. Lacoste started this week, and she is already working hard to learn the intricacies of our contracting program.

Mr. Berger reported that Round 1A payments for the Private Hospital Supplemental Fund were issued the last week of December and, to the best of his knowledge, all eligible hospitals have received their checks.

Mr. Berger informed the Commission that the Governor released his budget on Tuesday afternoon. Mr. Berger asked Bob Sands of the Department of Finance to give the Commission a brief overview of the Medi-Cal and other health-related items in the proposed budget.

Mr. Sands reported that the Governor's Budget includes $34.7 billion for Medi-Cal. He indicated $13.7 billion is from the State General Fund. The proposed budget

reflects an increase of $974.7 million over the 2005-06 revised budget. About $542 of this amount is from the State General Fund. The primary driver for the increase is the elimination of the one-time savings for Medicare Part D, which represents $212 million in State General Funds. There is an increase in Medicare Part A and B premiums that the state pays for dual eligibles. Caseload is expected to increase by 126,600 individuals, a 1.9 percent increase. Total enrollment will be 6.8 million. One of the big program changes in the Governor's Budget is the children's healthcare initiative. This initiative will enroll more eligible children into Medi-Cal and Healthy Families programs. Mr. Sands indicated that currently an estimated 428,000 children are eligible for one of the two programs. This outreach would target those children.

Mr. Sands stated that there are several proposals to help implement the Olmstead decision to put individuals who are eligible and are in nursing care facilities into the community. Those proposals total $1.6 million in State General Funds. There is also a proposal to increase outreach for managed care for seniors and persons with disabilities. Currently these persons can voluntarily enroll into managed care, and this proposal is to promote managed care enrollment. This would mean working with the advocates to come up with a plan to make sure that those health plans and communities are prepared to actually handle these populations.

In response to a question raised in regards to the implementation of this proposal, Mr. Douglas of the Department of Health Services (DHS), indicated that it will be part of the process as the State develops the infrastructure on the state level as well as at managed care plans to serve the needs of seniors and persons with disabilities. Over the year and a half that DHS is developing the infrastructure, DHS will be working to identify those counties and managed care plans that are ready to implement mandatory enrollment for seniors and persons with disabilities.

Mr. Sands indicated that there is $208,000 in the general fund for a coordinated care management pilot program. This would target individuals with chronic diseases who may be at the end of their lives. It will also target people with serious mental illness to better coordinate their care and make sure that they are getting the appropriate care.

Mr. Sands reported that there are some reforms to help the adult day healthcare centers to unbundle the current flat rate that is provided to adult day healthcare centers and also to hire some nurses to inspect these facilities to combat fraud. There is a proposal to freeze the amount of money that the State compensates counties for their administrative overhead associated with eligibility determinations. It would freeze the State's contribution at the 2005-06 level rather than provide the statutorily required Cost of living adjustment (COLA), which would save the State $21.2 million in general funds. Lastly, a new staff position has been proposed for CMAC.

IV. Department of Health Services Report

Toby Douglas reported that DHS is continuing to work with Centers for Medicare & Medicaid Services (CMS) and the public hospitals on the definition of the terms and conditions for the Certified Public Expenditures (CPE) methodology.

Mr. Douglas stated that there were three major issues and DHS has worked through two of three issues with CMS. One relates to which cost reports DHS will use in determining patient cost for uninsured as well as Medi-Cal beneficiaries. He said CMS will allow DHS to use the Medi-Cal cost reports. The second issue is the intern and residents program. CMS is allowing the state to count the program as CPE services. The last outstanding issue is related to payments for physician services. CMS has not yet determined whether DHS can include physician payments as part of the hospital cost under both the safety net care pool and the Medi-Cal Disproportionate Share Hospital (DSH) program.

In response to Commissioner Griffith's inquiry regarding the coverage initiative Mr. Douglas indicated that as part of the 1115 Demonstration Project Waiver Terms and Conditions there is $180 million set aside for years three, four, and five to cover initiatives, which will look for ways to expand coverage to the uninsured. DHS is required, as part of the Terms and Conditions to submit a concept proposal. This proposal could describe a broad concept of where the state is going with this coverage initiative. DHS will be working with stakeholders to finalize details and submit a proposal.

In response to Commissioner Griffith's follow-up inquiry, Mr. Douglas indicated that DHS will be submitting a proposal to CMS in the next couple of weeks and will forward a copy of the proposal to CMAC's Executive Director at that time.

V. New Business/Public Comments/Adjournment

There being no further new business and no comments from the public, Commissioner Warner recessed the open session. Commissioner Warner opened the closed session, and after closed session items were addressed, adjourned the closed session, at which time the Commission reconvened in open session. Commissioner Warner announced that the Commission had taken action on hospital care contracts and amendments in closed session. At this time, the open session was reconvened to hear from all interested parties regarding the Distressed Hospital Fund. A summary of this portion of the meeting is attached (Attachment A). The open session was then adjourned.

Summary of Public Comments on Distressed Hospital Fund

January 12, 2006 Commission Meeting

Rob Fuller – Downey Regional Medical Center

- Purpose behind distressed hospital fund program (DHF) should be to save essential health care infrastructure and the safety net system;
- Funds should be directed to non-Disproportionate Share Hospital (DSH) facilities facing closure that will commit to providing essential services (OB, NICU) as a condition of receiving funds;
- DHF should be a stand-alone program apart from other programs and aimed at facilities that cannot compete for current supplemental programs, and funds could be disbursed as time-limited rate increases of two years, rather than as supplemental payments;
- There should be no more than 4-6 recipients each year.

Jay Krishnaswamy – Doctors Medical Center Modesto

- DHF program should be aimed at safety-net hospitals that provide critical services like trauma, NICU (level II and III), and ER;

Barbara Glaser – California Hospital Association

- Basic problem is the State's under funding of Medi-Cal, and the DHF is only a minor step towards fixing that problem;
- CMAC should address any hospitals disadvantaged with a low contract rate before awarding it any DHF monies;
- All DSH facilities should be deemed to meet the "substantial volume" criteria, but successful competitors should demonstrate that at least 40% of their operating deficit comes from Medi-Cal losses;
- Rural hospitals should be treated slightly differently;
- CMAC should evaluate competitors on a case-by-case basis, and should leave the universe of eligible hospitals fairly wide open;
- CMAC should only award a small number of payments semi-annually, and only disburse 95% of the available funds each year.

Andy Leeka – Good Samaritan Hospital, Los Angeles

- CMAC should base their decisions on an approach driven by objective, standardized data from Office of Statewide Health Planning and Development (OHSPD) and other credible sources;
- The aim of the program should be to keep hospitals from going out of business;
- In order to be eligible, a hospital should have lost money 3 years in a row;
- By Good Samaritan's determination, roughly five hospitals in the state would qualify for DHF.

Charity Bracy – California Children's Hospital Association

- Program should focus on the critical role played by safety net hospitals;
- CMAC should take into account both FFS and managed care volume, as well as inpatient and outpatient services provided;
- Program should focus on short-term crises;
- Eligible hospitals should demonstrate that they are in the top 2 of adult and pediatric market share in their Health Facility Planning Area (HFPA);
- As they see it, about 135 hospitals would be eligible, of which 85-90 are DSH;
- They envision a semi-annual process.

Conway Collis – Daughters of Charity

- Suggest a "core" hospital concept be adopted, considering the role each competitor plays in their communities when considering the "critical component" criteria;
- Commission should take into account the applicant's commitment to the Medi-Cal program, and exclude facilities that have left or threatened to leave the program;
- Commission should focus some of the funds on facilities that have been adversely impacted by the closure of nearby DSH facilities;
- Small amount of the funds should be targeted at communities as a way to save services and systems community by community;
- In evaluating financial hardship, a facility's debt-to-capital ratio should be considered, as this will affect their ability to seek outside funding.

Catherine Douglas – PEACH

- Authors of SB 1100 intended for DHF to be inclusive of DSH facilities, not exclusive of them, and all DSH facilities should qualify for consideration;
- Safety net hospitals were not guaranteed that they would be stabilized through SB 1100, and the key components were not resolved;
- Substantial volume can be determined by evaluating hospitals against a statewide mean for Medi-Cal utilization;
- CMAC should consider whether or not an applicant has access to other sources of funding;
- Commission should take a broader policy approach when implementing the DHF;
- There should be a finite (small) number of recipients.

Doug Cumming – Oroville and Temple Community Hospitals

- Oroville believes that priority should be given to nonprofit, safety net, nonaffiliated sole community providers facing closure;
- Temple believes the focus should be on nonaffiliated facilities that fall just short of qualifying for DSH, and that can demonstrate losses from providing services to Medi-Cal patients;

- Even though this money came from DSH sources, it should not be inferred that eligibility is limited to DSH facilities.

Melissa Stafford Jones – California Association of Public Hospitals

- Uncertainty has increased under the new waiver;
- Preventing instability is the public hospitals' goal;
- Priority should be given to DSH facilities, as the money came from IGTs and the DHF program is contained in the waiver that provides for the DSH renewal;
- Non-DSH facilities should be required to demonstrate that their financial hardship results from Medi-Cal as well as uninsured patients;
- Non-DSH recipients should be required to disclose the amount of charity care they provide.

Russ Inglish – Integrated Healthcare Holdings, Inc.

- Applicants should be required to submit audited financial statements;
- CMAC should consider parent corporation assistance when evaluating applicants;
- Net financial distress should be calculated in determining financial hardship;
- Funds should be apportioned amongst several categories, with 40% of the funds going to hospitals with insufficient funding to continue operations, 20% going to hospitals in counties without a county or district hospital, 20% going to hospitals facing closure of a vital service, and the remaining 20% going to hospitals physically or operationally damaged by a natural disaster.

Tammy Wilcox – Catholic Healthcare West

- Eligibility should not discriminate between DSH and non-DSH participants;
- The top focus of the funding should be to reduce the adverse impact from the closure of services, and access to essential services;
- Commission should consider the essential services that would be unavailable if funding wasn't provided to an applicant;
- Inpatient and outpatient losses should be considered;
- They envision that no more than 50 hospitals would be eligible, and if more than 25 received funds, the impact of the funding would be diminished.

Irwin Hansen – Doctors Medical Center, San Pablo

- A distressed hospital should meet the balance sheet and operating loss test in bankruptcy law as a failing organization;
- Commission should take into account the social and delivery system impact upon a community if a hospital failed, as well as the impact upon the State general fund;
- Aim to make substantial financial impact with DHF disbursements.